INFORMATIONAL REPORT ON ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS PROGRAMS ANNUAL SURVEY CURRICULUM SECTION

Background: At its Winter 2015 meeting, the Commission directed that each Review Committee review a draft of its discipline-specific Annual Survey Curriculum Section during the Winter meeting in the year the Survey will be distributed. The Commission further suggested that each Review Committee review aggregate data of its discipline-specific Annual Survey Curriculum Section, as an informational report, when the materials are available following data collection and analysis. The Commission noted that all survey data is considered confidential at the programmatic level.

The Curriculum Section of the Commission's Annual Survey is conducted for both orthodontics and dentofacial orthopedics residency programs and clinical fellowship training programs in craniofacial and special care orthodontics in alternate years. The most recent Curriculum Section was conducted in August/September 2022. The next Curriculum Section will be conducted in August/September 2024. The draft Curriculum Sections are provided in **Appendix 1** and **Appendix 2** for review by the Review Committee on Orthodontics and Dentofacial Orthopedics Education.

Summary: The Review Committee on Orthodontics and Dentofacial Orthopedics Education is requested to review the draft Curriculum Section of its discipline-specific Annual Survey (**Appendix 1** and **Appendix 2**).

Recommendation:

Prepared by: Ms. Yesenia Ruiz

Part II - Orthodontics & Dentofacial Orthopedics Curriculum Section

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

21. What percentage of time do students/residents devote to each of the following areas during the entire program?

Column must add up to 100%. Do not enter percent signs.

a. Clinical (include related laboratory activity)	☐ %
b. Didactic (include assigned laboratory activity)	☐ %
c. Research	☐ %
d. Teaching	☐ %
e. Other, please specify ☐	☐ %
Total	☐ %

22. In which of the following interdisciplinary approaches did students/residents receive instruction or gain clinical consultation experience during the past 24-month period for the management of dental patients?

	Yes	No
a. Case history	○	○
b. Cephalometric analysis	○	○
c. Intraoral radiographs	○	○
d. Model Analysis	○	
○ d-1. Model Analysis: Plaster cast	○	
○ d-2. Model Analysis: Digital models	○	
○		
e. Photographics	○	○
f. Cone beam imaging	○	○
g. Other, please specify [ ]	○	○

23. What percentage of all patients are managed by the students/residents in each of following treatment mechanisms?

Column must not exceed 100%. Do not enter percent signs.

a. Fixed appliance (with or without a functional appliance)	[ ] %
b. Aligners (with or without a functional appliance)	[ ] %
c. Functional appliance (alone)	[ ] %
d. Other, please specify [ ]	[ ] %
Total	[ ] %

24. What clinical procedures exist to ensure program objectives are met?

Check all that apply.

- ☐ Experience with pre-surgical orthopedics for infants born with cleft lip and palate
- ☐ Orthodontic therapy for craniofacial deformities patients from the primary through adult dentition
- ☐ Orthodontic management of patients with cleft or craniofacial anomalies
- ☐ Surgical/orthodontic treatment planning
- ☐ Pre- and post-surgical orthodontic management
- ☐ Surgical splint design and construction and observation of surgical fixation splints in the operating room to assure appropriate placement
- ☐ Orthodontic treatment for patients who are medically compromised, have disabilities and/or special needs
- ☐ Participation in interdisciplinary dental care, clinical support and appropriate guidance for dentists who provide restorative services for Craniofacial Anomalies and Special Care (CFA&SC) patients
- ☐ Exposure to Oral and Maxillofacial Surgery, Pediatric Dentistry, Plastic and Craniofacial Surgery, Sleep Disorders, Genetics, and Speech and Language Pathology for additional exposure to management of CFA&SC patients
- ☐ Supervised participation in craniofacial team activities
- ☐ Participate in craniofacial team meetings

25. What is the average number of patients managed per student/resident during the 2021-22 academic year?

☐

26. What is the average number of surgical orthodontic cases per student/resident managed with the active participation of the students/residents during the 2021-22 academic year?

☐

Use this space to enter comments or clarifications for your answers on this page.

27. What is the TOTAL number of patients with craniofacial abnormalities managed with the active participation of the students/residents during the 2021-22 academic year?

28. What is the average number of patients per student/resident initiating active treatment that were assigned to the students/residents during the 2021-22 academic year?

a. 1st year students/residents

b. 2nd year students/residents

c. 3rd year students/residents

Total

29. What is the average number of patients per student/resident who completed active treatment by the students/residents during the 2021-22 academic year?

a. 1st year students/residents	
b. 2nd year students/residents	
c. 3rd year students/residents	
Total	

30. What is the average number of active retention patients managed per student/resident during the 2021-22 academic year?

a. 1st year students/residents	
b. 2nd year students/residents	
c. 3rd year students/residents	
Total	

31. Indicate the number of faculty positions and total number of hours per week devoted to the clinical supervision of the students/residents.

For example, if there are three clinical faculty members who each devote 30 hours per week to clinical supervision, the number of positions would be 3 and the total number of hours per week would be 90.

	Number
a. Number of faculty positions	
b. Total number of hours per week	

32. How often does the program conduct formal documented evaluations of student/resident clinical performance?

- ◯ Weekly
- ◯ Monthly
- ◯ Quarterly
- ◯ Biannually (i.e., twice a year)
- ◯ Annually

33. How often does the program conduct formal documented evaluations of faculty?

- ◯ Weekly
- ◯ Monthly
- ◯ Quarterly
- ◯ Semiannually
- ◯ Annually

Use this space to enter comments or clarifications for your answers on this page.

Part II - Clinical Fellowship in Craniofacial and Special Care Orthodontics Curriculum Section

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

21. What clinical procedures exist to ensure program objectives are met?

Check all that apply. At least one item must be checked.

- ☐ Experience with pre-surgical orthopedics for infants born with cleft lip and palate
- ☐ Orthodontic therapy for craniofacial deformities patients from the primary through adult dentition
- ☐ Orthodontic management of patients with cleft or craniofacial anomalies
- ☐ Surgical/orthodontic treatment planning
- ☐ Pre- and post-surgical orthodontic management
- ☐ Surgical splint design and construction and observation of surgical fixation splints in the operating room to assure appropriate placement
- ☐ Orthodontic treatment for patients who are medically compromised, have disabilities and/or special needs
- ☐ Participation in interdisciplinary dental care, clinical support and appropriate guidance for dentists who provide restorative services for Craniofacial Anomalies and Special Care (CFA&SC) patients
- ☐ Exposure to Oral and Maxillofacial Surgery, Pediatric Dentistry, Plastic and Craniofacial Surgery, Sleep Disorders, Genetics, and Speech and Language Pathology for additional exposure to management of CFA&SC patients
- ☐ Supervised participation in craniofacial team activities
- ☐ Participate in craniofacial team meetings

22. Which of the following experiences exist in the program for each student/fellow?

Check all that apply. At least one item must be checked.

- [ ] Regularly scheduled grand rounds case presentations
- [ ] Historical and current scientific literature review
- [ ] Research methodology and biostatistics
- [ ] Training in the allied medical sciences and social services required to manage the unique needs of CFA&SC patients and their families

Use this space to enter comments or clarifications for your answers on this page.

23. What is the average number of patients completing a full sequence of treatment logged by each student/fellow per year?

Full sequence of treatment includes each of the following: pre-, post-, and long-term treatment, diagnosis and planning, use of specialized orthodontic appliances specifically for the management of CFA&SC patients; and retention.

24. What is the average number of orthognathic cases managed per student/fellow during the 2021-22 academic year?

25. What is the average number of patients with craniofacial abnormalities managed per student/fellow during the 2021-22 academic year?

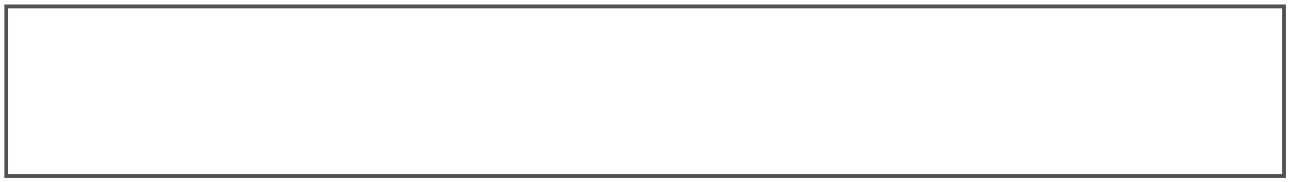
26. What is the average number of patients per student/fellow initiating active treatment during the 2021-22 academic year?

27. What is the average number of retention patients managed per student/fellow during the 2021-22 academic year?

28. What is the average number of patients per student/fellow who completed active treatment during the 2021-22 academic year?

Use this space to enter comments or clarifications for your answers on this

page.



29. Indicate the number of faculty positions and total number of hours per week devoted to the clinical supervision of the students/fellows.

For example, if there are three clinical faculty members who each devote 30 hours per week to clinical supervision, the number of positions would be 3 and the total number of hours per week would be 90.

	Number
a. Number of faculty positions	
b. Total number of hours per week	

30. How often does the program conduct formal documented evaluations of students'/fellows' clinical performance?

- ◯ Weekly
- ◯ Monthly
- ◯ Quarterly
- ◯ Semiannually
- ◯ Annually

31. How often does the program conduct formal documented evaluations of faculty?

- ◯ Weekly
- ◯ Monthly
- ◯ Quarterly
- ◯ Semiannually
- ◯ Annually

32. Does anyone else treat the patients of the orthodontic students/fellows?

	Treat craniofacial anomaly patients? Yes	No	**Number of craniofacial anomaly patients**
a. Orthodontic students/residents	◯	◯	☐
b. Postdoctoral students/residents in other types of programs	◯	◯	☐

	Treat special care needs patients? Yes	No	**Number of special care needs patients**
a. Orthodontic students/residents	◯	◯	☐
b. Postdoctoral students/residents in other types of programs	◯	◯	☐

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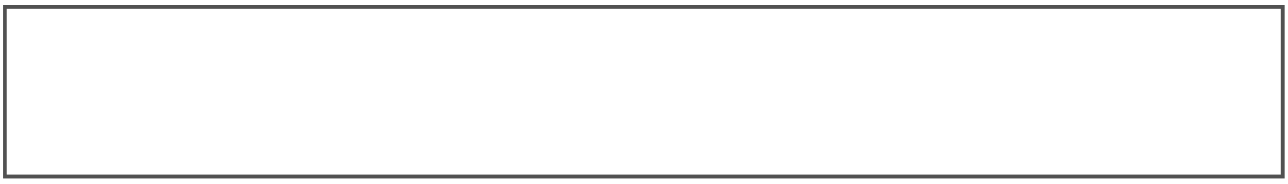

CONSIDERATION OF PROPOSED REVISION TO THE ACCREDITATION STANDARDS FOR ADVANCED DENTAL EDUCATION PROGRAMS IN ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS RELATED TO FACULTY RATIOS

Background: On September 18, 2023, the Commission on Dental Accreditation (CODA) received a request from Dr. Daniel Rinchuse, professor and program director of the orthodontics and dentofacial orthopedics education program at Seton Hill University, to consider a proposed revision to Standards 2-9 and 2-10 of the Accreditation Standards for Advanced Dental Education Program in Orthodontics and Dentofacial Orthopedics. The request is found in **Appendix 1.**

Dr. Rinchuse believes that Standards 2-9 and 2-10 of the Orthodontics and Dentofacial Orthopedics Standards should be reviewed and revised related to the required faculty to student/resident ratios.

Summary: The Review Committee on Orthodontics and Dentofacial Orthopedics Education and the Commission on Dental Accreditation are requested to consider the letter from Dr. Daniel Rinchuse **(Appendix 1)**. If revisions to the Accreditation Standards are proposed, the Commission may wish to circulate the proposed revisions to the communities of interest for review and comment.

Recommendation:

Prepared by: Ms. Yesenia Ruiz

From: Daniel Rinchuse
To: Tooks, Sherin
Cc: Susan Yochum
Subject: CODA Faculty to Student ratios
Date: Monday, September 18, 2023 1:43:01 PM

Date: September 18, 2023

RE: Discussion points for CODA, Faculty to resident ratios

Dear Dr. Sherin Tooks, CODA Senior Director:

The purpose of this letter is to briefly comment on the new CODA requirements regarding the number of faculty to student/resident ratios. I write this from the perspective of someone who has been in graduate orthodontic education for 47 years, and has earned a PhD in Higher Education from the University of Pittsburgh. Importantly, I would have you consider our concerns even though we are a rather small orthodontic program of 8 residents per year and in compliance with these ratios:

- *The program must ensure a minimum of one (1) full time equivalent (FTE) faculty to four (4) students/residents for the entire program, including clinical, didactic, administration, and research components. (Standard 2-9)*

- *For clinic coverage, the program must ensure no less than one (1) faculty to eight (8) students/residents to assure the number and time commitment of faculty is sufficient to provide full supervision of the clinical portion of the program. (Standard 2-10)*

How were these ratios determined? Is there any educational foundation? Is this based on oral surgery residencies? Oral surgery and orthodontics are likely the most polar opposite advanced dental education (specialty) programs, with oral surgery potentially needing more supervision because of relatively high morbidity compared to orthodontics with relatively little morbidity, and no mortality.[1] Jerrold,[2] an orthodontist and attorney, argued that orthodontics is essentially elective, correcting a malocclusion is not medically necessary, and "for the most part, humans can live very well with crooked teeth."

Specific faculty to resident ratios can be punctilious, arbitrary, capricious, simplistic, and not considering the many ramifications. For instance, for a 30-month program like ours, half of the year the faculty to student/resident ratios will be different. Particularly, at Seton Hill University we have 8 residents per year so half the year we have two classes for a total of 16 residents, and the other half we have three classes for a total of 24 residents. Also, the number of patients seen by residents per day is not factored in. For example, in one program residents could be seeing 4-6 patients per day (*at Seton Hill University*) while in other programs residents may be seeing as many as 20 or more patients.

It could be argued that graduate students may need less academic supervision than undergraduates since more responsibility for their own education is required of them. In other words, learners should be the agents of their own learning.[3] The teacher being more of a guide, fostering curiosity, creativity, innovations, and life-long learning. With emphasis on metacognition, the process of the student reflecting on and directing his/her own thinking and learning, learning becoming more self-directed. Especially at the graduate level, learning is more ubiquitous, with no boundaries, happening everywhere at any time. This would align with focus on learning rather than teaching.[3,4]

These ratios, requiring more faculty, are going to tremendously increase the cost of an orthodontic education with already exorbitant student debt. In their 2019 article Samson and Schwartz[5] reported orthodontic accumulative educational debt as being as high as $700,000-$1,000,000. Stoker et al[6] suggested that orthodontics may be nearing a "bubble market" where the educational debt outweighs the gain.

There is already a significant orthodontic faculty shortage,[7] which has been identified years ago.[8,9] Trotman et al[9] concluded in their article: "As the dental profession enters the new millennium, it is faced with a serious manpower shortage caused both by the retirement of aging faculty and clinical practitioners, and by a decrease in the number of people entering dental education." To this point, Vaden[10] wrote that we lack qualified and enlightened teachers. He went on to say that: "Many bright young graduates who would make great educators have so much debt, and so many family demands, that they seek what are, at present, more lucrative avenues in the private sector." How will orthodontic programs be able to recruit quality faculty? Hiring by numbers only and not experience and quality, will result (and is currently readily observed as Vaden remarked) in having inexperienced and under qualified faculty. All faculty are not the same,[11-13] and education should ultimately not be a numbers game only.

We would appreciate very much your response to our concerns, and would encourage further dialogue.

REFERENCES

1 Rinchuse DJ, Rinchuse DJ. Orthodontics justified as a profession. Am J Orthod Dentofacial Orthop 2002;121:93-96.

2 Jerrold L. Insulation from liability? Maybe. Am J Orthod Dentofacial Orthop 2019;156:878-880.

3 Ambrose SA, Wankel LA. Higher education's road to relevance. Jossey-Bass:Hoboken, NJ, 2020.

4 Eyler R. How humans learn: the science and stories behind effective college teaching. West Virginia University Press:Morgantown, 2018.

5 Samson G, Schwartz M. Corporate dentistry, corporate orthodontic history, reality and strategic planning. Sem Orthod 2019;25(4):304-306.

6 Stoker AC, Schwarz E, Doyle L, Iwasaki LR. Opinions, plans, and demographics of orthodontic residents: A follow-up study. Am J Orthod Dentofacial Orthop 2020;157:809-17.

7 Hussain SR, Jiang SS, Bosio JA. Generational perspectives of orthodontists in the U.S. and Canada: A survey study. Am J Orthod Dentofacial Orthop 2022;162:824-838.

[8] King G. Solving the faculty shortage might require more than money. Am J Orthod Dentofacial Orthop 2015;148:200-201.

[9] Trotman CA, Bennett E, Scheffler N, Tulloch JC. Faculty recruitment, retention, and success in dental academia. Am J Orthod Dentofacial Orthop 2002;122:2-8.

[10] Vaden JL. Our pefect storm: One orthodontist's opinion. Am J Orthod Dentofacial Orthop 2016;149:587-589.

[11] Rinchuse DJ, Rinchuse DJ. The use of educational-psychological principles in orthodontic practice. Am J Orthod Dentofacial Orthop 2001;119:660-663.

[12] Rinchuse DJ, Rinchuse DJ, Kandasamy S. Evidence-based versus experience-based views on occlusion and TMD. Am J Orthod Dentofacial Orthop 2005;127:249-254.

[13] Rinchuse DJ, Sweitzer EM, Rinchuse DJ, Rinchuse DL. Understanding science and evidence-based decision making in orthodontics. Am J Orthod Dentofacial Orthopl 2005;127:618-624.

Sincerely,

Daniel Rinchuse, DMD, MS, MDS, PhD
Professor and Program Director
Advanced Education Program in Orthodontics and Dentofacial Orthopedics
Seton Hill University, Center for Orthodontics
2900 Seminary Drive Bldg E
Greensburg, PA 15601
drinchuse@setonhill.edu

CONSIDERATION OF PROPOSED REVISIONS TO IMPROVE DIVERSITY IN DENTAL AND DENTAL RELATED EDUCATION PROGRAMS

Background: On December 1, 2023, the Commission on Dental Accreditation (CODA) received a letter from The National Coalition of Dentists for Health Equity (TNCDHE). The request is found in **Appendix 1**. In its letter, TNCDHE provides short-term and long-term suggestions to CODA to improve diversity in all academic dental, allied dental, and advanced dental education programs.

The short-term suggestions from TNCDHE include:

1. Better training of site visit teams on how to assess whether an educational program has implemented a plan to achieve positive results.
2. Ensuring site visit teams are inclusive of educators who represent diversity, such as in race, color, national or ethnic origin, age, disability, sex, gender, gender identity, and/or gender expression, and sexual orientation. Further, when possible, site visit team members should be representative of dental schools with demonstrated success in increasing diversity and assuring a humanistic environment.
3. Redefining the meaning and intent of "diversity" in the Standards, considering the recent Supreme Court decision. While the term diversity can no longer specifically relate to race with respect to admissions other characteristics such as family income, first-in-college-in-family, socioeconomic status, birthplace, gender identity and sexual orientation, and other attributes might be used as hallmarks of diversity.

The long-term suggestions from TNCDHE include:

1. Achieving a humanistic environment, addressing discrimination in policies and practice. Suggested revisions to the Accreditation Standards for Predoctoral Dental Education Programs were provided.
2. Review of student admissions related to the underrepresented segments of the population enrolled in dental schools. Suggested revisions and additions to various Accreditation Standards were provided.
3. Considering Standards related to an inclusive environment in dental education. Suggested revisions and additions to various Accreditation Standards were provided.
4. Considering Standards related to access to care among diverse populations. Suggested revisions and additions to various Accreditation Standards were provided.

Summary: The ORTHO Review Committee and Commission are requested to consider the letter from The National Coalition of Dentists for Health Equity (**Appendix 1**). If proposed revisions are made to the Accreditation Standards, the Commission may wish to circulate the proposed revisions for a period of public comment.

Recommendation:

Prepared by: Dr. Sherin Tooks

December 1, 2023

Dr. Sherin Tooks, EdD, MS
Director, Commission on Dental Accreditation
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611
tookss@ada.org

Dear Dr. Tooks,

Recommendations to increase diversity in dental education and practice via the Commission on Dental Accreditation Standards

The National Coalition of Dentists for Health Equity's mission is to support and promote evidence informed policy and practices that address inequities in oral health. One of our priorities is to advocate for greater diversity among dental students and faculty to better reflect the diversity of the US population in the oral health workforce.

In November of 2022, we wrote to the Commission on Dental Education (CODA), expressing concerns about the lack of diversity in predoctoral dental education and the apparent lack of enforcement of the CODA standards on diversity (hot link to our letter on our website). We observed that despite these standards, no dental schools (as of 2022) had received a recommendation related to diversity over the ten years that the standards had been in place. Our letter recommended new standards, policies, and procedures that would enhance diversity in predoctoral dental education. We were pleased to learn that CODA accepted our letter and referred it to a committee reviewing potential changes in the predoctoral standards and that the committee's report will be considered in the early 2024 CODA meetings.

Since 2022, we have spent additional time reviewing CODA standards for the other academic dental educational programs including dental hygiene, dental therapy and advanced education programs and realized our recommendations should also apply to these other programs. In this letter, we review our original recommendations, and propose additional ones for all educational programs.

We believe that the dental school accreditation standards utilized by CODA serve a vital role in achieving a diverse oral health workforce. However, we also believe that the current CODA predoctoral education standards do not appear to be encouraging academic dental institutions to recruit a more diverse student body or faculty. CODA adopted the new diversity predoctoral education standards 1-3 and 1-4 about ten years ago. However, recent data from the American Dental Education Association shows that "between 2011 and 2019, the percentage of HURE applicants increased only 2.2% annually on a compounded basis, Additionally, the proportion of all HURE dental school first-year, first-time enrollees for the entering class increased by only 3% between 2011 (13%) to 2019 (16%) (ADEA Report-Slow to Change: HURE Groups in Dental Education, https://www.adea.org/HURE/)" The conclusion we draw is that dental schools are not doing enough to recruit more HURE students to meet the intent of the CODA Standards.

We recognize that the recent Supreme Court decision to abolish the use of race in making admission decisions will prevent academic dental institutions from using race as a determining factor in admissions. The recommendations we make below do not suggest or presume that strategy.

In this letter, we are offering several additional suggestions to CODA to improve the diversity of all academic dental education programs, including predoctoral, dental hygiene, advanced educational programs and dental therapy. Three of these are short term recommendations that are not related to changing accreditation standards, with the understanding that CODA appropriately takes considerable time in changing standards which entails seeking input from many individuals, communities, and entities. In addition, we make another set of suggestions that are long term and include modifications to the “Examples of evidence to demonstrate compliance” for some of the standards. Our recommendations are based on papers found in recent Special Editions of The Journal of Public Health Dentistry and the Journal of Dental Education.

In particular, the longer-term suggestions build on the recommendations of the paper by Smith, PD, Evans CA, Fleming, E, Mays, KAI Rouse, LE and Sinkford, J, 'Establishing an antiracism framework for dental education through critical assessment of accreditation standards, as well as two additional papers in the Special Edition including Swann, BJ, Tawana D. Feimste, TD, Deirdre D. Young, DD and Steffany Chamut, S, 'Perspectives on justice, equity, diversity, and inclusion (JEDI): A call for oral health care policy;' and Formicola, AJ and Evans, C, 'Gies re-visited.' Note that some of these recommendations were included in the previous letter to CODA sent on November 4, 2022

SHORT-TERM SUGGESTIONS

Suggestion 1: We recommend that site visit teams be better trained on how to assess whether an educational program has implemented a viable plan that achieves positive results. Under the structural diversity section of the Standards, it is stated clearly that the numerical distribution of students, faculty and staff from diverse backgrounds will be assessed. Assessment is appropriate but showing an improvement in the diversity of the dental schools’ academic communities based on the school's plans and policies should also be demonstrated.

Since site visit teams are different for each school, there can be no consistency in the assessment process unless site visitors are given explicit expectations of what schools should demonstrate to comply with each of the two standards. CODA should develop a specific detailed orientation for each site visit team on what is acceptable and what is not acceptable for each of these two standards.

Suggestion 2: To be better able to assess whether schools meet diversity and humanistic standards, site visit teams should be inclusive of educators who represent diversity, such as in race, color, national or ethnic origin, age, disability, sex, gender, gender identity, and/or gender expression, and sexual orientation. Wherever possible, site visit team members should also be representative of dental schools that have demonstrated success in increasing diversity and assuring a humanistic environment.

Suggestion 3: Especially in light of the recent Supreme Court decision, CODA should redefine the meaning and intent of the term "diversity" in the Standards documents. While the term diversity can no longer specifically relate to race with respect to admissions other characteristics such as family income, first-in-college-in-family, socioeconomic status, birthplace, gender identity and sexual orientation, and other attributes might be used as hallmarks of diversity.

LONG-TERM SUGGESTIONS

1) Achieving a humanistic environment- Not much is known about how dental schools address discrimination in their humanistic environment policies and practices. Although school policies on anti-discrimination might exist, students, faculty, and staff from underrepresented populations may still experience microaggressions, discrimination, racism, and barriers to socialization and mentorship. It has been suggested that such experiences may be underreported due to numerous factors, including fear of retaliation and/or disbelief that such concerns will be adequately addressed by the dental school. Because there are small numbers of underrepresented students, faculty, and staff in some dental schools, even anonymous humanistic surveys may not reveal these issues.

Suggested new "Examples of evidence to demonstrate compliance with Predoctoral Education Standard 1-3 may include:"

- Policies and procedures (and documentation of their effectiveness) implemented to seek feedback from traditionally underrepresented individuals concerning their experiences with the school's environment.
- Results of feedback that the school has sought from underrepresented students, faculty, and staff about their experiences with the school's environment.
- Documentation of the number and types of problems, complaints, and grievances reported about the school's environment, together with documentation of the school's effectiveness in addressing these issues.

2) Student Admissions

Despite the historical lack of students and faculty from underrepresented segments of the population enrolled in US dental schools, it appears that dental schools are rarely cited for not meeting Standard 1-4. One reason for this may be that the standard allows dental schools to set their own interpretations and expectations for student and faculty diversity. As a result, diversity at some dental schools may not appropriately emphasize certain specific underrepresented segments of the population and/or entirely represent the diversity of the local and regional population surrounding the schools, and/or reflect the national demographics in which the schools' graduates will practice their profession. Additionally, CODA provides no specificity for the level of engagement, with respect to recruitment, that dental schools should have with underrepresented populations

Suggested new "Examples of evidence to demonstrate compliance may include".

- Documentation that the school has implemented policies, procedures, and strategies to attract and retain students, faculty and staff from diverse backgrounds in order to achieve parity with the diversity profiles of the school's local, regional or national populations
- Documentation of longitudinal improvement in the diversity of the school's students, faculty, and staff. Where improvement is absent or minimal, documentation of the evaluation of strategies to improve diversity and of modifications made to these strategies to improve outcomes.

The intent of Standard 1-4 states that "admissions criteria and procedures should ensure the selection of a diverse student body with the potential of successfully completing the program". A problem is that the interpretation of this intent can vary dramatically from school to school. Admissions decisions are made by committees of people, and although there are trainings and processes to address implicit biases toward traditionally underrepresented applicants, the admissions process is still largely subjective. There are unique social and structural issues that exist for underrepresented applicants that must also be considered when assessing their potential for success. Those issues may influence undergraduate education academic achievements including GPA's and standardized tests. The question to admissions committees shouldn't necessarily be which applicant has the higher score, but rather does an applicant demonstrate appropriate academic achievements, despite a history of significant barriers, to successfully negotiate the curriculum.

Suggested new "Examples of evidence to demonstrate compliance may include:"

- Documentation of policies and procedures used to consider the unique social and structural constructs that affect traditionally underrepresented applicants in the admissions decision-making process.

- Documentation of procedures used to educate admissions committee members to implicit biases that may exist with respect to the potential of underrepresented applicants to excel in the academic program.
- Documentation of admissions criteria intended to assess not only academic achievements, but also the interest, desire, and commitment of applicants to learn about issues such as cultural competency, community-based practice, and addressing inequities in oral health within the population.

Standards 4-4 for Predoctoral Dental Education programs and Standard 4-2 for Dental Therapy programs state "Admission policies and procedures must be designed to include recruitment and admission of a diverse student population". There are no accreditation standards for Dental Hygiene or Advanced Educational programs that mandate that these programs have policies and practices to achieve a diverse student population. It is recommended that CODA add these standards with appropriate intent statements and examples of evidence to document compliance.

Generally, with respect to Standards 1-3, 1-4, and 4-4, we recommend that CODA strengthen the accountability that should undergird the standards. There must be accountability around these standards. Accountability must be built into the process of reviewing the standards, supporting site visitors in their work, and making sure that dental schools who fail to meet the standards are required to improve their practices and those dental schools who are exceeding the standards should be encouraged to continue to grow.

3) Inclusive Environments in Dental Education

Underrepresented students have a more difficult time achieving both success and a feeling of belonging in dental educational programs for a myriad of reasons.

To improve retention of students in dental education programs facing academic, social or emotional challenge, it is recommended that CODA strengthen the intent statement for student services (Standard 4-7 for predoctoral programs and Standard 4-12 for the dental therapy programs).

The intent statement should state "programs should have policies and procedures which promote early identification and subsequent mentoring/counseling of students having academic and/or personal issues which have the potential of affecting academic success or the personal well-being of students".

Dental Hygiene and Advanced Education programs have no accreditation standards that address academic or personal support for students having difficulties. It is recommended standards be added.

4) Access to Care among Diverse Populations

Access to dental care, and therefore oral and systemic health, is significantly compromised by a number of factors including race, gender, sexual orientation, economic status, education, and neighborhood environment, among other factors.

CODA should strengthen the intent statements with respect to graduates being competent in treating patients in all life stages (predoctoral standard 2-22, dental hygiene standard 2-12 and dental therapy standard 2-20) to assure that foundational knowledge is taught and clinical competence is assessed with respect to changes in oral physiology, the management of the various chronic diseases and associated therapeutics associated with aging, as well as psychological, nutritional and functional challenges manifested in many of these patients.

The intent statement of predoctoral standard 2-17, which addresses student's competence in managing a diverse population, is vague. It is recommended CODA strengthen predoctoral standard 2-17 by stating that "graduates MUST (currently reads should) learn about factors and practices associated with disparities in health status among vulnerable populations, including structural barriers, and must display competency in understanding how these barriers, including prejudices and policies regarding, but not limited to race, gender, sexual preferences, economic status, education and neighborhood environment, affect health and disease and access to care".

There are no standards for dental hygiene or advanced education programs that mandate that graduates be competent in treating a diverse population. CODA should add such standards to these programs.

According to the intent statement of predoctoral Standard 2-26, students working in community health care or service-learning settings are essential to the development of a culturally sensitive workforce. However, the standard merely states that the program makes available such learning environments and that students be urged to avail themselves of such opportunities. CODA should mandate the student's participation in service-learning and/or community-based health centers clinics.

We are pleased to submit these suggestions to CODA and we hope they will be considered by CODA in our mutual efforts to increase the diversity of the dental workforce.

Sincerely,
Dr. Lawrence Hill DDS MPH
President, National Coalition of Dentists for Health Equity

cc:
American Dental Education Association - Dr. Karen West, President; Sonya Smith, Chief Diversity Officer, American Dental Education Officer

The National Coalition of Dentists for Health Equity is a national organization of accomplished dentists dedicated to assuring that everyone has an equitable opportunity to access high quality, affordable dental care.

National Dental Association - Tammy Dillard-Steels, MPH, MBA, CAE, Executive Director; Dr. Marlon D. Henderson, President; Dr. Kim Perry, Chairman of the Board
Diverse Dental Society – Dr. Tamana Begay, President
American Dental Therapy Association – Cristina Bowerman MNM, CAE, Executive Director
Hispanic Dental Association - Dr. Christina Meiners, 2023 President; Juan Carlos Pierotti, Operations Manager
Society of American Indian Dentists - Dr. Cristin Haase, President; Janice Morrow, Executive Director;
American Dental Association – Dr. Ray Cohlmia, Executive Director; Dr. Jane Grover, Council on Advocacy for Access, and Prevention; Dr. Linda J. Edgar, President
American Dental Hygienists' Association – Jennifer Hill, Interim CEO; JoAnn Gurenlian, RDH, MS, PhD, AAFAAOM, FADHA Director, Education, Research & Advocacy
Community Catalyst – Tera Bianchi, Director of Partner Engagement; Parrish Ravelli, Associate Director, Dental Access Project
National Indian Health Board – Brett Webber, Environmental Health Programs Director; Dawn Landon, Public Health Policy and Programs Project Coordinator
American Institute of Dental Public Health – David Cappelli Co-Founder and Chair; Annaliese Cothron, Executive Director

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